DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-04

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
January 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Sections 1905 (a)(26) and 1934 of the Soc. Sec. Act

7. FEDERAL BUDGET IMPACT
a. FFY 03 $1,000,000,000
b. FFY 04 $2,000,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4-19 B page 42

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4-19 B pages 42, 43

10. SUBJECT OF AMENDMENT:

School Based Health Services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
Barry S. Maram

13. TYPED NAME: **Barry S. Maram**

14. TITLE: **Director of Public Aid**

15. DATE SUBMITTED

16. RETURN TO:

Illinois Department of Public Aid
Bureau of Program and Reimbursement Analysis
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 12/1/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
MAR 26 2003
DMCH - IL/IN/OH

FORM HCFA-179 (07-92)

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES, OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

01/03

Special Rehabilitation Services and Non-emergency Transportation Services Provided by Local Education Agencies

Reimbursement for each service will be based on the cost incurred by the local education agency (LEA) in providing a 15-minute unit of that service. The cost shall be determined annually by using the uniform cost calculation methodology established by the Department and may include the cost of practitioners, materials and supplies necessary to provide the service, and indirect costs. The value of educational resources will be specifically excluded from the cost determination. All costs must be documented, based on the previous fiscal year's costs and inflated to the midpoint of the current fiscal year, using the most recently published Medical Economic Index available to the Department.

In the event that no historical costs exist for a specific practitioner, the LEA shall estimate the cost of providing the service for the current year, based on the calculation below, using an inflation rate of 0% for Row L. Following the completion of a school year, a revised cost calculation form must be submitted to the Department using actual costs. Rates will be adjusted in the event of any overstatement of costs.

LEA-specific costs of providing an individual service, other than those for non-emergency transportation, shall be determined for each service, using the following calculation:

A.	Total full time equivalents providing this service.		
B.	Total annual hours service providers were required to work		
C.	Total annual hours service providers worked on the provision of this direct service.		
D.	Percent of hours providing this service (quotient of C divided by B)	%	
E.	Total amount of salaries and benefits paid to relevant service providers	$	
F.	Total amount of salaries and benefits related to this service (product of D and E)		$
G.	Cost of non-salary expenses attributable to the provision of this service		$
H.	Total direct cost of providing service (sum of F and G)		$
I.	Indirect cost rate	%	
J.	Indirect cost of providing service (product of H and I)		$
K.	Last year's total cost of providing service (sum of H and J)		$
L.	Inflationary adjustment rate	%	
M.	Inflationary cost (product of L and K)		$
N.	Total current cost (sum of K and M)		$
O.	Hourly cost of providing this service (quotient of N divided by C)		$
P.	Cost per 15 minute billing unit (quotient of O divided by 4)		$

Total hours providing a service reported in row C above must include face-to-face time, as well as preparatory and follow-up time necessary for a direct service event, as defined in Code H.3 of the Illinois Guide for School-Based Health Services Administrative Claiming.

Costs of providing allowable group services shall be based on the individual calculation above, multiplied by the Medicare Relative Value Unit scale for calendar year 2002.

Special Non-emergency Transportation Services Provided by a Local Education Agency

Reimbursement will be based on the cost incurred by the LEA to transport a disabled child to and from a source of medical service. All costs must be documented, based on the previous fiscal year's documented costs.

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES, OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

Individual round trip costs shall be equal to the total reported special education transportation costs, as reported to the Illinois State Board of Education (ISBE) in the Annual Claim for Pupil Transportation Reimbursement (ISBE Form 50-23). Using this form, or as updated by the ISBE, allowable transportation costs shall equal total reported special education transportation costs reported on line 23C, divided by the total number of special education students reported on line 9, divided the number of days in the LEA's school year. Only qualifying transportation trips may be billed to the Department.

Qualifying transportation trips means the provision of transportation where each of the following conditions are met:

A. Special transportation is necessary for the child's medical condition and is documented in the child's Individual Education Plan,

B. A non-transportation medical service is provided on the day of the transportation, and

C. The LEA provides special accommodations in providing the transportation service, beyond what is otherwise provided to all students in routine transportation.

10/96 ~~Reimbursement is on a fee-for-service basis. Payment will be the lesser of charge or fee screen using a uniform fee schedule. A maximum fee schedule is developed. The maximum fee schedule is reviewed and specific rates may be adjusted downward or upward so that the rate included in the uniform fee schedule is comparable to other provider fee schedule rates for similar services. Adjustments will not result in reimbursement rates below the amount necessary to ensure access to services.~~

10/96 ~~The maximum fee schedule rates are based either on 1993 statewide expenditure data maintained by the Illinois State Board of Education or on 1994 expenditure, staffing and service provision data from a statewide representative sample of community providers. The maximum fee schedule accounts for the resources necessary to deliver services including overhead. Consistent use of statewide expenditure date will avoid duplication of direct and indirect cost categorization. Direct and indirect costs may be identified by an approved cost allocation plan for any relevant community based provider. These direct and indirect costs will not be included in the cost allocation plan for school based services.~~

~~The value of educational resources will be excluded from rate determination.~~

10/96 ~~The maximum fee schedule determination is consistent with Medicare reimbursement principles detailed in 42 CFR Part 413 Subparts A through G and the Office of Budget and Management Circular A-87. The methodology used is within the upper limits of payment set in 42 CFR 447.321 and 447.325 for outpatient hospital services and clinic services and other inpatient and outpatient facilities.~~

~~The maximum fee screen (FS) for each covered service is calculated using the formula:~~

$$FS = \frac{(DR) + (IR)}{(AH)} \times SH$$

~~DR = Annual direct health resources including staff and supplies~~
~~IR = Annual indirect resources as determined by application of an indirect cost rate analysis schedule to direct resources~~
~~AH = Annual service hours of care possible related to direct and indirect resources~~
~~SH = Hours of care per individual covered service~~

~~The uniform fee schedule may be adjusted annually, either upward or downward, based on the DRI medical inflation index. Adjustment of the uniform fee schedule will not result in reimbursement rates below the amount necessary to ensure access to services.~~

~~The payment differential between individual and group service rates is based on the most current published version of Medicare's Resource Based Relative Value Scale (RBRVS) relative value units (RVUs).~~